EDITRENDS

A Monthly Bulletin on Epidemiology & Public Health Practice in Washington State

Hunger in Washington State Many Families Lack a Consistent Food Supply

Ninety percent of U.S. households report having consistent access to enough food for a healthy, active life, without needing emergency or other extraordinary food sources in the past year (Nord et al. 1999). However, many families in Washington State are not secure about availability of sufficient food — a problem termed food insecurity. Households with children are especially likely to report food insecurity, although adults will generally report going hungry themselves before having their children go hungry.

A Washington State telephone survey, the Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Department of Health, between 1995 and 1999 asked respondents about food insecurity and hunger experienced during the

past month. This survey revealed that 5% of the respondents were concerned about having enough food, 3.6% skipped a meal, and 1% went without food for an entire day because of not having enough food or money for food. Based on an estimated population of 4,162,000 adults in Washington in 1998, approximately 42,000 adults (95% CI, 34,000–50,000) each month go without eating for an entire day because of a lack of food or money for food.

It is not clear how Washington compares to the rest of the United States. According to a recent national survey (the Current Population Survey Food Security Supplement, FSS), the rate of food insecurity in Washington was significantly higher (nearly 12%) than the U.S. average (9.7%),

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State Launches Toll-Free Tobacco Quit Line

Washington's new statewide Tobacco Quit Line fielded its first calls on November 15. It is designed to address concerns of health care providers by offering patients barrier-free access to high-quality tobacco cessation programs. Modeled after successful programs in Oregon and California, the Quit Line draws upon a sophisticated database and offers:

- individual, in-depth counseling that includes motivation and problem-solving advice;
- up-to-date information about pharmacological support;
- information about cessation benefits offered by health plans;
- information and referral to other cessation services, including local resources;
- a "Tobacco Quit Kit" containing custom-selected materials for each patient;
- follow-up calls to some uninsured and Medicaid callers who used Quit Line services;
- information for health care providers about cessation techniques and resources.

Anyone can call the Quit Line (see box, page 2). Special materials are available for teens, pregnant women, Spanish-speaking patients, and friends and relatives who want to offer support. Professional tobacco cessation specialists are well trained in evidence-based methods. Health care providers are encouraged to refer patients and follow up to assess the service they receive. Providers can check out the Quit Line by calling the toll-free number or by ordering brochures to use when making patient referrals (see page 2).

The Quit Line is a key component of the new Tobacco Prevention and Control Program recently unveiled late last year by the Department of Health (DOH) *Continued page 2*

If only 500 of 10,000 callers (5%) successfully end their tobacco addiction, the life spans of these callers can increase by a combined total of 2,500 years.

Tobacco Quit Line (from page 1)

and funded through the state's share of the historic tobacco industry settlement signed in 1998. Other program components include television, radio, and print ads, and community and school-based programs aimed at helping both adults and youth understand the consequences of smoking and chewing tobacco.

Washington's Quit Line is by far one of the most comprehensive in the country; however, there are some things it does not do. It does not supply free or reduced-price nicotine patches (except to a small number of uninsured and Medicaid patients). It does not provide comprehensive follow-up phone support to patients with health insurance. And, it is no substitute for specific physician advice delivered during the course of routine office care. DOH will be working to increase availability of covered cessation services through health plans and insurers and to provide training to physicians and other healthcare providers in brief office techniques that work.

Updated Clinical Practice Guidelines

Significant recent progress in treating tobacco addiction has prompted the U.S. Public Health Service to release an updated clinical practice guideline, *Treating Tobacco Use and Dependence* (see sidebar). This guideline reflects new, evidence-based recommendations from randomized, controlled trials of clinical interventions that increase the likelihood of a patient's success

Washington Tobacco Quit Line & Information Resources

1-877-270-STOP — Calls are toll-free.

TTY line for the hearing impaired: 1-877-777-6534
Spanish Language line: 1-877-2 NO FUME

Caller translation services for other languages are available on the main line.

Information Resources

Quit Line Brochures (for referring patients); order by email, gloria.schroder@doh.wa.gov

Treating Tobacco Use and Dependence. Clinical practice guideline published by the U.S. Public Health Service, June 2000. To order, call 1-800-358-9295 or visit the Web site at http://www.surgeongeneral.gov/tobacco/default.htm)

at quitting. Key guideline findings include:

- Quit rates increase when a physician advises a patient to quit.
- Physicians are more likely to advise patients if their office staff treat tobacco use status as a vital sign.
- Every patient who is interested in quitting tobacco should be offered follow-up assistance, including both counseling and pharmacotherapy.
- Five pharmacological agents (four forms of nicotine replacement and one oral medication, bupropion) are effective in helping smokers to quit.
- Health care systems and insurers need to provide coverage and easy access to proven cessation services, as they would for other chronic medical conditions.
- Telephone counseling is effective.

Six Noninfectious Conditions Newly Added to List of Notifiable Conditions

As reported in the September issue of *EpiTRENDS*, the Washington State Board of Health has approved a sweeping revision of the notifiable conditions regulations. This revision consolidates nine different regulatory schemes for disease surveillance into a single, integrated regulatory framework.

Noninfectious conditions newly included in the regulatory framework are birth defects, blood lead levels, cancer (See WAC 246-102), hospitalized burns, occupational asthma, and pesticide poisoning. These conditions are included because the scope of public health epidemiology has changed in recent years. Public health authorities will use the information provided in reports to perform intervention activities. Notification requirements for these and other conditions are detailed in the revised regulations (Chapter 246-101 - Notifiable Conditions of the Washington Administrative Code) at: http://www.doh.wa.gov/os/ policy/246-101.htm

If you have questions regarding this regulatory revision or wish to receive a hard copy of the revised regulations, please contact: Greg Smith, MPA Washington State Department of Health Office of Policy, Legislative and Constituent Relations, P.O. Box 47879 Olympia, WA 98504-7879 (360-236-3704, or greg.smith@doh.wa.gov).

Monthly Surveillance Data by County

† Unconfirmed reports of illness associated with pesticide exposure.

^{*} Data are provisional based on reports received as of November 30, unless otherwise noted

^{§#} Number of elevated tests (data include unconfirmed reports) / total tests performed (not number of children tested); number of tests per county indicates county of health care provider, not county of residence for children tested; # means fewer than 5 tests performed, number omitted for confidentiality reasons



WWW Access Tips

For more information on hunger and food insecurity, visit the U.S. Department of Agriculture Web page at: http://www.ers.wsda.gov/ briefing/foodinsecurity/ reports.htm

Hunger and Food Insecurity References

Centers for Disease Control and Prevention: Self-reported concern about food insecurity – eight states, 1996–1998. *MMWR* October 20, 2000; 49(41): 933–936.

Nord M: Does it cost less to live in rural areas? Evidence from new data on food security and hunger. *Rural Sociology*, in press.

Nord M, Jemison K, Bickel, G: *Prevalence of food insecurity and hunger, by state, 1996–1998* (http://www.ers.usda.gov/briefing/foodsecurity/reports.htm).

Hunger (from page 1)

although the poverty rate in Washington was more than two percentage points below the national average during 1995 to 1997 (Nord et al. 1999). However, a better comparison might be eight states that used identical questions on their BRFSS surveys during 1996–1998. Washington's results did not differ from the average rate of food insecurity for these eight states. The Department of Health is tracking future survey results to clarify how Washington compares to the rest of the nation.

As might be expected, the Washington BRFSS revealed that lower income was associated with more food insecurity and hunger. This pattern occurred even though the respondents with the lowest incomes were more likely to be eligible for food stamps. It is not clear whether the relatively high rates of hunger among those with the lowest income are due to failure of eligible

families to access food stamps, or to residual food insecurity/hunger even after food stamp use. Nonwhite race or Hispanic ethnicity doubled the risk of food insecurity/hunger compared to that of white non-Hispanics.

Older age and rural residence were not associated with food insecurity/hunger. In fact, the highest-risk age group was 18-24. Persons over 65 were at the lowest risk for food insecurity/hunger even though they reported the lowest income of any age category. This may reflect the success of social programs aimed at reducing hunger among the elderly (e.g., Meals on Wheels). Also, the risk for rural dwellers was about one-third less than for urban dwellers. possibly due to availability of alternative food sources such as gardens. Other possible explanations are more sharing of food among neighbors or a lower cost of living (especially housing) in rural areas (Nord, in press).

Calendar

Feb. 23, 2001 Seattle **Zoonotic and Vector-Borne Disease: Current and Emerging Issues in Washington and the United States** — Conference sponsored by The Northwest Center for Occupational Health and Safety, University of Washington, and the Washington State Department of Health

Both emerging and established zoonotic and vector-borne diseases present a low but real risk to Washington residents. Examples include: rabies, hantavirus pulmonary syndrome, Lyme disease, *E. col*i O157:H7, tickborne relapsing fever, babesiosis, and erhlichiosis. This course covers the reasons for the emergence and re-emergence of such diseases, their epidemiology, and the signs and symptoms in their diagnosis and treatment.

The cost is \$125. Professional credit is available. For more information, call Sharmaine Guyll at 206-543-1069, or visit the Web site at http://depts.washington.edu/envhlth/conted/ce/course_descriptions/vbd01.html.

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ep/TRENDS is published monthly by the Washington State Department of Health.